State of New Hampshire Board of Pharmacy

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Quality Related Event (QRE) Report

Date of Report:		**Date of Incident:**		**Time of Incident:**	☐ A.M. ☐ P.M.
Type of Prescription Involved:	☐ New ☐ Refill	**How Received:**	☐ Hard Copy Rx ☐ Telephoned In ☐ Fax or E-Prescription		
If Telephoned In, Order Was Taken By:	☐ Pharmacist ☐ Certified Pharmacy Technician ☐ Not Applicable				
At What Level Was the Event Discovered?	☐ Patient ☐ Prescriber ☐ Pharmacist ☐ Pharmacy Staff ☐ Other:				
Was the Patient Harmed?	☐ Yes ☐ No	**Describe Incident Type** (Check All That Apply)	☐ Wrong Medication ☐ Transcription Error ☐ Incorrect Dosage ☐ Labels Switched ☐ Mislabeled/Misread ☐ Allergy Not Listed in Profile ☐ Communication Error ☐ Incorrect Directions or Usage ☐ Other:		

Describe in detail what happened – be specific using facts only – no opinions. Do not include names or any other patient, prescriber or pharmacy staff identifiers. Attach additional sheet if required.

Medication Ordered		**Medication Actually Dispensed**	
Name		***Name***	
Strength		***Strength***	
Quantity		***Quantity***	
Directions		***Directions***	

Using the description of the six stages of filling a prescription (explained at end of this form), at what stage of the process does it appear that the problem originated:

☐ Stage One ☐ Stage Two ☐ Stage Three ☐ Stage Four ☐ Stage Five ☐ Stage Six

Whom was the initial cause of the error related to:	☐ Pharmacist ☐ Intern ☐ Technician ☐ Prescriber ☐ Patient ☐ Presciber's Office Staff ☐ Other:						
Did the error reach the patient?	☐ Yes ☐ No	**Did the patient use / ingest the medication?**	☐ Yes * ☐ No	**If yes, did this result in an adverse reaction to the patient?**	☐ Yes ☐ No	**Patient's Age:**	
Was the patient counseled?	☐ Yes ☐ No	**Is documentation of patient counseling available?**	☐ Yes ☐ No	**Was a "Prospective Drug Review" completed?**	☐ Yes ☐ No	**Where in the process was the "Prospective Drug Review" Completed?**	☐ During Rx data entry ☐ During Rx final verification
Was this a "Central Fill Processing" Prescription?	☐ Yes * ☐ No	*** If Yes, name and location of pharmacist?**					

Initial data entry of prescription information was performed by:	❑ Pharmacist ❑ Intern ❑ Certified Technician ❑ Registered Technician *					
***If registered technician, has technician been trained on data entry?**	❑ Yes ❑ No	*** Is there documentation available that the registered technician completed Board approved data entry training?**		❑ Yes ❑ No		
Upon completing the data entry, did the computer identify any problem with drug interaction, dosage alert, etc.?	❑ Yes ❑ No	**Did the computer require the pharmacist or technician to do a "manual over-ride"?**		❑ Yes ❑ No		
During the dispensing process, did the "stock" bottle accompany the finished product up to the time of final verification?	❑ Yes ❑ No	**Did the "original" hard copy prescription physically follow the order through the process to the point of verification?**		❑ Yes ❑ No		
Was the "original" prescription "scanned" into the system?	❑ Yes ❑ No	**Was the dosage ordered (for administration) different than the commercially available form of the medication?** (example: Zantac ® 75mg/5ml Sig: 25 mg once daily.)		❑ Yes ❑ No		
How many hours was the pharmacy open the day the incident occurred?		**Staffing level at pharmacy on the day of the incident?**	❑ Usual staffing level ❑ Reduced staffing level *			
If staffing was reduced / lower than usual, please explain why (i.e. vacation, sick, etc.)						
Number of pharmacists on duty at the time of incident?		**Total number of pharmacist hours that day?**		**Total time in hours of pharmacist "overlap" on day of incident?** (i.e. more than 1 RPh on duty at same time)		
Number of pharmacy technicians on duty at the time of incident?		**Does the PIC (Pharmacist-In-Charge) or staff pharmacist have the ability to regulate the scheduling of pharmacists and/or technicians?**	❑ Yes ❑ No	**Scheduling is done by? (title only)**		
Does the PIC (Pharmacist-In-Charge) have any input into the scheduling?	❑ Yes ❑ No	**Did any other store personnel become involved in the incident?** (i.e. front store manager, PDM, etc.)	❑ Yes * ❑ No	**If Yes, identify all involved by title only:**		
Total number of prescriptions (new & refill) that were filled at the pharmacy on the date of the incident?	❑ 0 - 50 ❑ 51 - 100 ❑ 101 - 150 ❑ 151 - 200 ❑ 201 - 250 ❑ 251 - 300 ❑ 301 - 350 ❑ 351 - 400 ❑ 401 - 500 ❑ 501 - 600 ❑ Over 600					

Any unusual distractions on the date of the incident? (If so, explain)

Any other issues that might have contributed to the incident? (Be brief and specific)

How could the handling of the incident been improved?

What system or process changes could help to avoid a similar recurrence?

Submitter's Printed Name		**Submitter's Signature**		**Date**	
Submitter's Title	❑ Pharmacist-In-Charge ❑ Staff Pharmacist ❑ Pharmacy Intern ❑ Pharmacy Technician ❑ Other:				

Stages of filling a Prescription

- **Stage 1:** Receiving the Prescription
- **Stage 2:** Data Entry
- **Stage 3:** Prescription Assembly
- **Stage 4:** Pharmacist Final Check
- **Stage 5:** Addressing the Issues
- **Stage 6:** Delivery to the Patient

Stage One:
Receiving the prescription. This is when phone-in, electronic, faxed, or physically delivered prescriptions start their journey culminating with the ingestion of the drug by the patient. At this stage it is important to find out everything that reasonably can be known about the patient. Is this a child or an older adult? Are there significant allergies? If it is a refill request, has the drug been working? What other medications are being used? Later on in the chain of events, the responses to these questions may take on greater importance.

Stage Two:
The second stage usually involves data entry. A person trained to do so will input information into the computer, and that information will become the electronic record upon which everyone within the pharmacy will subsequently rely. Inaccurate data entry could result in serious consequences to the patient. It is much easier to get this step right than it is to later recognize that an error has occurred.

Stage Three:
The third stage centers on prescription assembly. A correct vial or other container must be chosen. The correct label must be affixed to the correct container, with the correct medication inside the container. All of this must be done as a singular process in order to avoid confusing one prescription with another. At the end of this stage, there should be a prescription, a stock container of medication from which the medication was obtained, and a labeled container of medication for the patient. These things should be kept together for each patient, perhaps in a basket that separates them from medications for other patients.

Stage Four:
The fourth stage requires a final review of the prescription-filling process by the pharmacist. At this point, everything previously done by a pharmacy technician, another pharmacist, or the pharmacist who filled the prescription, is reviewed to ensure accuracy. There is no single “gold standard” for how this is done. Some pharmacists use the NDC number as a way to compare what is in the stock bottle with what is listed on the computer printout. Others shake out and visualize on the cap, a supply of the medication. It is probably important to vary the approach to this final review from time-to-time to prevent bias that leads people to see what they expect to see rather than what is really there. Pharmacists frequently address soft edits at this stage, resolving problems identified by the computer.

Stage Five:
The fifth stage addresses any issues that may arise. These may include queries emanating from the prescription software program, denials by third-party payers, the need for communication with the prescriber or patient, and ambiguities related to the intended course of therapy. It is important to place aside these issues until they are able to be resolved in order to avoid time-consuming backlogs. Other patients should not have to wait unnecessarily for their prescription to be filled while another patient’s prescription is awaiting resolution of an issue.

Stage Six:
The sixth and final stage is the delivery of the medication, with counseling if necessary or requested, to the patient. This is the time to make sure that auxiliary labeling, if appropriate, has been affixed to the container, that the computer information leaflet has been included, and that the patient being given the drug is the one for whom it has been prescribed. Any particularly critical pieces of information should be emphasized to the patient, and any questions answered.